Maryland Health Quality and Cost Council
Friday, December 19, 2011
Joint Committee Hearing Room, Dept. of Legislative Services Building
Annapolis, Maryland
9:30 a.m. – 12:00 p.m.

MEETING NOTES

Members present: Lt. Governor Brown (Chair), Sec. Joshua Sharfstein (Vice Chair), James Chesley, Richard "Chip" Davis, Barbara Epke, Roger Merrill, Peggy O'Kane, Marcos Pesquera, E. Albert Reece, Jon Shematek, Kathy White, and via telephone, Christine Wray.

Members absent: Jill Berger, Debbie Chang and Lisa Cooper.

Staff: Laura Herrera, Frances Phillips, Ben Stutz, and Grace Zaczek.

Meeting Materials

All meeting materials are available at Council's website:
http://dhmh.maryland.gov/mhqcc/meetings.html

Welcome and Approval of Minutes

The Lieutenant Governor called the meeting to order at 9:55 AM. He welcomed the members, thanked them for all their efforts in the Council's workgroups, and welcomed Delegate Shirley Nathan-Pulliam. The Secretary noted that the Council's annual report gave a bird's eye view of Council activities and accomplishments for 2011. The September 26, 2011 meeting minutes were approved.

UPDATE PRESENTATIONS

Health Disparities Workgroup – E. Albert Reece, University of Maryland School of Medicine

Dr. Reece's presentation is available on the Council's website. Dr. Reece said it has been a pleasure to chair this workgroup, whose members all attended virtually every one of the 7-10 meetings. He presented the workgroup's report and recommendations that focused on five disparities: workforce; quality of care within an office or hospital setting; access to care within a health plan or healthcare system; understanding of care within a healthcare setting; and others as would be determined by the workgroup.

The workgroup is recommending a "Health Enterprise Zone" (HEZ) as a first strategy to reduce disparities. The zone would be a designated area eligible to receive additional resources and incentives for providers to locate and serve underserved individuals, including minorities. Residents in these zones would be empowered to take more responsibility for and to have more

control over their health care. The workgroup has had a robust discussion highlighting incentives, and required interventions and incentives, including those for reimbursement to improve quality of care in the HEZ.

The HEZ would increase access to all types of health services, expand the health care workforce and the number of community health workers in the HEZ, improve community leadership development, reduce racial and minority health disparities and improve minority health outcomes, and reduce preventable hospital admissions and emergency department visits. The workgroup proposed creating a statute-based incentive program that would be available to all parties in the HEZ with a variety of financial approaches. Funding would be needed for Health Information Technology in the HEZ, and to expand loan assistance repayment programs for health professionals, especially physicians. The workgroup proposed assessment benchmarks to measure the HEZ's effectiveness.

The second strategy will be a "Maryland Health Innovation Prize." Different from a grant which is given for an idea, the prize would be awarded for results. The goal is to encourage people to be creative in identifying effective approaches to reducing disparities that could be expanded to cover the entire state. The prize would provide public recognition and a financial reword for innovative health interventions. The selected innovations could be replicated in the wider community, and could reduce minority health disparities in a local community and statewide. The workgroup suggested identifying an "Accountable Care Organization" that would build the "purse" to fund the prize, and would administer it.

The third approach that the workgroup identified is to expand the scope of the current reimbursement incentives for quality and to make them race and ethnicity-specific. These included hospital and primary care-specific incentives. Data tracking would need to be race and ethnicity-specific, and if not currently feasible, the workgroup recommended asking the MD Health Care Commission (MHCC) and the Health Services Cost Review Commission (HSCRC) to study the feasibility of tracking such data. The commissions would be asked to identify methods for tracking the data.

Dean Reece said that these strategies could have a major impact on improving significant disparities in asthma, diabetes and heart disease among Maryland residents. Health interventions at a statewide level would target the modifiable factors most associated with these disparities.

Secretary Sharfstein thanked Dean Reece and the entire workgroup for their outstanding efforts, and for developing wide-ranging approaches to reducing minority health disparities across Maryland.

In response to Dr. Roger Merrill's question about how the level of uninsured African-American population could be determined in an HEZ, the Secretary stated that there are extensive data available online at the State Health Improvement plan website. The Lieutenant Governor said that applicants would propose the location of HEZs, and that there would be a limited number of zones designated across the state. Dr. Merrill added that the residents of wealthy areas can work around the lack of primary care providers by going to specialists, but these aren't available in poorer and rural areas. He suggested diverting specialists to primary care through the Loan

Assistance Repayment Program (LARP). The Secretary commented that LARP is one strategy for increasing the pool of primary care providers.

Secretary Sharfstein again thanked the workgroup for their excellent efforts, and briefly noted the economic costs of health disparities, saying that it's not the gene code but the zipcode that defines disparities. Eliminating them decreases costs and saves lives.

Dr. James Chesley said that it was an excellent presentation and that the recommendations are very feasible. He commented that patients frequently use the Emergency Department (ED) for Primary Care as a clinic; then they are referred for follow up in the community. He said that years ago in Baltimore City and in Prince George's County, practitioners served one night a week in the ED, then followed the patients they saw there back in the community.

Dean Reece said the workgroup didn't want to create a framework that had to be maintained. He offered that a long term strategy would be to reduce the use of the ED for primary care, and suggested that community doctors be paid more to see people as an incentive to increase the availability of primary care.

The Secretary said it's an irony that areas with high hospital admissions are spending more money for worse outcomes. Dr. Sharfstein questioned whether it would be possible to release "trapped capital" as savings in the acute care system to fund primary care. He recommended public rather than sealed submissions for the Maryland Health Innovation Prize.

Dr. James Chesley moved to accept the Health Disparities Workgroup's report and recommendations. Dr. Kathleen White seconded the motion which passed unanimously on a voice vote of the members present.

The Lieutenant Governor stated that legislation would be drafted to include the Health Enterprise Zones in the Governor's legislative package, and workgroup members may be asked to testify in support of that legislation. The Secretary offered a special thanks to Dr. Carlessia Hussein, Director of DHMH's Office of Minority Health and Health Disparities (MOMHHD), and Dr. David Mann, Epidemiologist with MOMHHD for their extensive work on the report. Dean Reece acknowledged Brian DeFilippis, the Dean's Special Assistant and Ben Stutz, Policy Director for the Lieutenant Governor for their significant contributions to the report.

Evidence Based Medicine Workgroup – Richard 'Chip" Davis, Johns Hopkins Medicine

Dr. Davis, whose presentation is available on the Council's website, updated the Council on the Blood Wastage Collaborative. He said the Council should feel good about initiating this program. The collaborative effort among the Red Cross, DHMH, Johns Hopkins Hospital, LifeBridge Health, and the University of Maryland Medical System has created a process that the American Red Cross is considering for blood product inventory visibility in other regions around the country. In Maryland, the blood banks have found the data tracking to be time consuming, so they will continue to use the best practices that were developed, but will not report monthly data. As the Council closed out the project, the final tally was 1,663 units and $558,833 saved.

Dr. Davis then introduced Ms. Carmela Coyle who is serving in two capacities – as President and Chief Executive Officer for the Maryland Hospital Association, and as Director for the Maryland Patient Safety Center. Dr. Davis and Ms. Coyle met over the summer to define roles for the Workgroup and the Maryland Patient Safety Center (MPSC) as the day-to-day management of the Hand Hygiene initiative's data moves from Johns Hopkins on behalf of the Workgroup to the MPSC, which has engaged the Delmarva Foundation in data activities. The MPSC will continue as project lead in engaging stakeholders with the Workgroup continuing as the strategy advisor, providing guidance and consultation to MPSC.

The MPSC will speed the sharing of de-identified data with the hospitals. The MPSC, the Maryland Hospital Association and the MD Health Care Commission will work closely together on relating hand hygiene and healthcare acquired infections, with the goal of reducing infections. Ms. Coyle described the hand hygiene compliance rate parameters, with criteria for inclusion in the analysis: eighty percent of a hospital's required reporting units must have at least thirty observations, for the observations to be counted in the data. She noted that 32 of the state's 46 hospitals collected data in the fourth quarter of 2011, for a 70 percent participation rate. Ms. Coyle said that the observations were for staff exiting a room, not entering and exiting as shown in the presentation. Keeping the observers unknown to unit staff is a challenge, and the observer method is resource-intensive.

Ms. Coyle presented data that showed a 12-month upward trend in hand hygiene compliance for pediatric and medical/surgical critical care units, and a downward trend for neonatal intensive care and pediatric inpatient units in the same time period.

Next steps for the project include: the Council continuing to provide guidance, input and strategic advice on goals and objectives, the Hand Hygiene Steering Committee, composed of DHMH, Delmarva Foundation and MPSC reviewing data and outcomes in detail and generating ideas for advancing the project, and MPSC managing the collaborative activities and working with the other partners to achieve project objectives.

A major objective will be to increase hospital participation. A new set of standardized reports for hospital CEOs is in development, which will be integrated with CEO reports on hospital infections.

Secretary Sharfstein has sent letters to non-participating hospitals on the importance of becoming part of the project. Ms. Coyle said it would be helpful to understand why some hospitals aren't participating, and why some participating hospitals are trying, but not meeting the minimum reporting requirements. The MD Hospital Association wants to divide non-participating facilities into groups by the reasons why they didn't join the initial effort, to identify solutions to those specific barriers.

Dr. Davis commented that as a state, only South Carolina has done a Hand Hygiene project, so this is an opportunity for Maryland to be a real leader in having effective hand hygiene in all its hospitals. The goal isn't 100 percent hand washing, it's to link hand hygiene to reducing infections. He reported that MHCC staff is willing to produce preliminary CLABSI rates by

hospital by month for FY 2010 and FY 2011 for comparison to Hand Hygiene compliance data, with surgical site data to be available in 2012, and Multi-Drug Resistant Organism data to be available in 2013.

Ms. Barbara Epke commented that hand washing (or the lack of it) is the root of all evil in inpatient settings, and all Maryland hospitals are focused on it due to the rigor of the Hand Hygiene program, with most institutions finding their rates improving. She added that some physicians are listening to a DVD so they can observe other physicians. Dr. Merrill added that physicians respond to peer pressure.

The Secretary said participation is really low, and Ms. Peggy O'Kane said she was really disappointed with the unstable participation numbers. Dr. Roger Merrill noted that he was troubled with the "secret shopper" method for observations, as it's not sustainable. Dr. Merrill suggested a more automated data collection process, like a "clicker" outside the patient's room that could be hit when hands have been cleaned on exiting the room.

Dr. Davis acknowledged Dr. Merrill's suggestion on automation, stating that there are mechanical devices like a railroad crossing barrier that can come down across a doorway if hands aren't washed. He said the project's impact occurs as hand hygiene becomes a core competency for staff. When senior leaders make it a priority, then it becomes one. This also requires a "culture change." When a unit polices itself with immediate feedback to staff, then it has an impact on patient care, so real time monitoring is key to success.

The Secretary questioned how difficult is it for hospitals to participate, and do they need to be mandated to participate. He said that if the State is going to care about hand hygiene, it has to be addressed at the Public Health level, with hospitals expected to participate in the program. He will review the Department's authority to get hospitals to participate.

Ms. Coyle added that the program requires fundamentally changing human behavior. Ms. Epke said changing the culture is difficult; it's all about leadership, and she believed the Council will see a big improvement in the coming year. Ms. O'Kane agreed that the effort required a culture change in hospitals. Ms. Epke then noted that most hospitals are consulting internally and with others about possible disciplinary actions that can be taken to enforce hand hygiene.

The Lieutenant Governor said that there is a cost to not washing hands – it's more health care acquired infections. It's costing the state millions of dollars and doing a lot of harm. Mr. Brown asked the Council to think about what to do now. He recommended quantifying the cost of infections and exploring how to incentivize the necessary behavior change. Reducing infections will offset the cost of monitoring and incentives.

Ms. Coyle suggested letting the data drive the process, as the hospital CEOs haven't seen their facility's data. She said that there was a high of 21 hospitals which had enough data to participate in July and August, this dropped back to 11 over the fall. The Lieutenant Governor commented that this is less than half of the State's hospitals participating in the project.

Dr. Kathleen White recommended developing new standardized CEO-level reports for all hospitals, participating, or not, and that it takes 3 to 5 years to change culture. Dean Reece said that voluntary participation is not always the best way, and he advised requiring the hospitals to participate and to share data.

Dr. Davis then discussed possible next projects that were considered, but not chosen for the Evidence Based Medicine Workgroup. These were: mandatory flu vaccination for health care workers, which many hospitals already have instituted, and standardized care transitions for patients. Other initiatives reviewed, but not selected were: blood stream infections reduction in kidney dialysis units, reducing pressure ulcers in inpatients, and a smoking cessation program for inpatients, that might be addressed by DHMH's Office of Chronic Disease Prevention in collaboration with the DHMH Center for Health Promotion, Education and Tobacco Use Prevention.

Implementing the Hand Hygiene project in other settings (schools, nursing homes, rehab. centers, etc.), and academic detailing are potential new projects. This will be explored further, as Maryland Medicaid has created a partnership around this issue with the Maryland Health Insurance Program and the State Employees Health Benefit Program. A medication reconciliation project linked to academic detailing will have discussion. Ms. Barbara Epke suggested harm avoidance as a topic for the Workgroup to consider. Dr. Davis responded that the Workgroup is considering harm avoidance as a topic, possibly for Deep Vein Thrombosis Prevention, and other areas.

Dr. Davis reported that Dr. Cliff Mitchell, liaison between DHMH and Maryland Department of the Environment, is convening an advisory group that will meet in early 2012, to serve as a collaborative for hospitals which want to decrease their "red bag trash." In addition, Dr. Mitchell will be revising regulations, using the group's input to update the Maryland state requirements for regulated medical waste. The Regulated Medical Waste Workgroup will identify projects in three areas: clinical, operational and financial. Dr. Mitchell will give a brief update at the March, 2012 Council meeting.

Wellness and Prevention Workgroup and Healthiest Maryland Businesses – Christine Wray, via telephone

Ms. Wray's presentation is available on the Council's website. Ms. Wray, the Workgroup's new chairperson began with three announcements. First, she said she was excited to be leading the workgroup and described her Public Health background, her role as President of MedStar St. Mary's Hospital since 1992, and as a Senior Vice President for MedStar Health. Ms. Wray told the Council that DHMH has received a $1.9 Million Community Transformation grant from the Centers for Disease Control and Prevention in part because of the Council's leadership. The third item was to relate that through the Council's work, the State Employee Workplace Wellness and Food Procurement Strategy has been elevated to the Governor's office.

Ms. Wray discussed the recent grant which is funded through the Prevention and Public Health Fund of the Affordable Care Act. The Community Transformation Grants (CTG) will support community-level efforts to reduce chronic diseases such as heart disease, cancer, stroke, and

diabetes. By promoting healthy lifestyles, especially among population groups experiencing the greatest burden of chronic disease, the grant will help improve health, reduce health disparities, and control health care spending.

Maryland's grant is part of approximately $103 million awarded to a total of 61 states and communities throughout the U.S. DHMH received an initial award of $1,945,289 for September 30, 2011- September 29, 2012. The anticipated project period is five years. DHMH is 1of 13 state health departments that received awards to serve the entire state minus large counties of over 500,000 residents. Under the terms of the federal grant requirements, Baltimore City, Baltimore County, Anne Arundel, Prince Georges, and Montgomery Counties were excluded, and the state's efforts will focus on Maryland's 19 smaller jurisdictions. In addition to specific actions in the 19 covered counties, DHMH will undertake several statewide policy and environmental change initiatives. At least 50 percent of the funding must go to local activities. Consistent with the program's authorization, at least 20 percent of grant funds will be directed to rural areas. Maryland will use the CTG funds to tackle the root causes of chronic disease such as smoking, poor diet and lack of physical activity, and will expand the Healthiest Maryland efforts in tobacco-free living, active living and healthy eating, and in quality clinical and other preventive services (i.e., improving control of hypertension and high cholesterol).

Ms. Wray emphasized the importance of the funds as chronic diseases are responsible for 75 percent of health care costs in the United States. The Community Transformation Grant will provide support to local health departments to implement primary prevention efforts under the umbrella of Healthiest Maryland. She reported that although discussions are still in process with the CDC to finalize grant activities and outcomes, the proposed activities focus on Healthiest Maryland's four complementary components -- Healthiest Maryland Communities, Schools, Businesses, and Health Care.

One of the first activities of the Community Transformation Grant's Healthiest Maryland campaign was the Summit on Childhood Obesity, which was held in partnership with the University of Maryland Baltimore, and DHMH on November 15th and 16th. It brought together over 400 stakeholders from across the state to exchange and disseminate evidence-based information; produce an inventory of resources and programs in Maryland; and discuss the impact of current policies, health disparities, and cultural influences on childhood obesity.

Ms. Wray said this summit was the platform Maryland needed to launch the Institute for a Healthiest Maryland, and Healthiest Maryland Advocacy Network. Both launched in November with their own websites. The Institute for a Healthiest Maryland is a new resource for Maryland communities working to improve wellness across the state. Healthiest Maryland Advocacy Network will enable stakeholders to receive e-news updates and learn about many new valuable resources that will be coming to this website. Ms. Wray offered special thanks to the Lt. Governor Brown, Secretary Sharfstein, Deputy Secretary Phillips, and Dean Reece for participating in and leading Summit activities.

Ms. Wray presented ChopChop Maryland as an example of the types of resources and tools the

Institute will provide for Maryland's communities. ChopChop Maryland, recently launched by First Lady Katie O'Malley and DHMH is a new resource designed to promote fun and healthy eating for families. This initiative provides direct outreach to parents, and indirect outreach through partner organizations to parents and children aged 5-12 to connect families with fun healthy recipes.

Workgroup staff and representatives recently met with the Governor's Office and suggested four potential focus areas for State Employee worksite wellness: 1) establish and promote healthy food guidelines for State Agencies and Facilities, 2) establish tobacco-free State agencies and facilities, and 3) enhance evidence-based disease management benefits covered under the State's health plan. The Workgroup recommended convening critical partners (i.e. Departments of Budget and Management, Education, General Services, DHMH, Public Safety and Corrections) to explore the implementation of these focus areas.

Ms. Wray next reported that the number of Healthiest Maryland Businesses (HMB) participants is now 150 companies, reaching 200,000+ Maryland employees. The Workgroup has increased its goal to recruiting 225 companies by the end of 2012. Since the last MD Health Quality and Cost Council meeting, HMB staff has participated in 20 activities to recruit companies and to enhance the technical assistance provided to Maryland employers. Four HMB companies and partners were highlighted as best practices during a seminar at the Summit on Childhood Obesity as local businesses and initiatives that aim to make the connection between family and community health.

Strategies to enhance HMB include regional technical assistance and recognition events (i.e. regional employer forums) to enhance outreach to small businesses and to provide targeted outreach through social media. Ms. Wray acknowledged Dr. Merrill's efforts on behalf of HMB, with special thanks to him for brainstorming with staff to identify better strategies to facilitate peer-to-peer learning and sharing in Maryland. She asked council members to participate in HMB events and to highlight their organizations as local wellness success stories.

Ms. Wray emphasized the Council members' role in the Community Transformation Grant as advancing policy and programmatic issues, identifying and disseminating success stories, holding stakeholders accountable, and advocating for transformation in their local communities.

Telemedicine Task Force – Robert Bass, Maryland Institute for Emergency Medical Services Systems

Dr. Bass' presentation is available on the Council's website. Dr. Bass explained that the last Telemedicine Taskforce focused on stroke care. The Council recognized the need to expand the scope of telemedicine activities in Maryland beyond stroke care, forming the current taskforce, directed by MIEMSS and the Maryland Health Care Commission, at the request of former DHMH Secretary John Colmers. Dr. Bass described the activities of the taskforce's three advisory groups – Clinical, Technology Solutions and Standards, and Financial and Business Model. He said there was much cross-pollination among the groups which recognized the benefits of telemedicine in urban as well as rural areas. The groups learned that telemedicine increased patient satisfaction with healthcare, especially in Virginia, and decreased medical

isolation for providers in rural areas. He noted that CareFirst has begun a voluntary program to reimburse providers statewide in Maryland for telemedicine services.

The Clinical Advisory Group, which was composed of 30 participants including clinicians, hospital administration, public health, rural health, and other interests, defined clinical issues and use cases. It made recommendations to the other committees, and developed scenarios to demonstrate the potential uses and benefits of telemedicine.

Dr. Bass explained that the evidence is rapidly growing on telemedicine's benefits, which include improved access and health outcomes; reduced ED visits and hospital admissions/re-admissions; reduced travel; and increased patient and provider satisfaction. The group identified continuing barriers to implementing telemedicine widely in Maryland - reimbursement; credentialing; licensing across state borders; lack of coordinated state leadership; and lack of broadband access.

The Clinical Advisory Group recommended approaches to overcoming these barriers: State regulated payors should reimburse for telemedicine services; aligning COMAR 10.32.05 hospital credentialing regulations with recent changes at CMS; streamlining medical licensing procedures for physicians who provide telemedicine services across state borders; improving State leadership and promoting telemedicine development by designating a lead state agency for telemedicine; establishing a telemedicine Advisory Committee; possibly designating a non-for-profit to support telemedicine development efforts; and integrating telemedicine with HIE/CRISP; and considering a pilot telemedicine program at MIEMSS (trauma, stroke, STEMI, etc.)

The Technology Solutions and Standards Advisory Group, with approximately 30 participants consisting of hospital Chief Information Officers, representatives from the state-designated health information exchange, clinicians, local health departments, and technology vendors, made recommendations regarding the standards that are required to support interoperable telemedicine in Maryland. The group discussed the current functionalities of the technology available to implement telemedicine, and examined standards that support interoperability from other industries.

Dr. Bass reported that based on the information the group gathered, it drafted principles for interoperable standards, and considered various standards and criteria that need to be adopted statewide to support interoperability of telemedicine which build on existing health IT initiatives. Organizations that adopt telemedicine should meet certain minimum requirements related to privacy and security, technology, and connectivity to a centralized telemedicine network.

Finally, the advisory group developed a model for telemedicine networks to connect to a centralized network operating center. The group recommended creating a provider directory service that identifies providers available to consult on care at the point of delivery, and that the directory should be included in a centralized telemedicine network.

The Financial and Business Model Advisory Group, which consisted of physicians, health plans' representatives, telemedicine health experts, and advocates addressed funding for telemedicine services. The group reviewed principles of payment for telemedicine: distance site (location of consultant) and originating site (location of patient), and recent efforts of other states and positions of advocacy groups such as American Telemedicine Association.

The advisory group considered current approaches used by payers such has Medicare which limits reimbursable geography to where access is a problem; the commercial market which is governed by the laws of the State, as CareFirst and UnitedHealthCare pointed out with the Virginia law, and the Maryland Medicaid program which has limited geography and a limited pilot program in behavior health. Public payers voiced concerns about additional costs in a difficult budget environment, and workgroup staff worried about costs of additional mandates and impact on Medicaid.

Dr. Bass said the group recommended implementing statewide access to telemedicine. State-regulated payors should reimburse for telemedicine services, and telemedicine should be reimbursed when the service is judged clinically equivalent to a face-to-face visit. Equivalency can be assessed using existing structures and standards applied by carriers via coverage rules (prospective) and utilization review (retrospective).

The advisory group recommended payments should be made to distance site and originating site, with distance site receiving payment similar to face-to-face services, and the originating site receiving a small administrative fee for providing the location for service. The group didn't make any recommendation on the level of payment at either sites, but suggested that appropriate payments be evaluated. The group did recommend considering alternative payment approaches besides Fee-For-Service. Lastly, the panel recognized that budget challenges may limit Medicaid participation, but urged that the existing pilot for behavioral health should continue.

Secretary Sharfstein thanked Dr. Bass for a thorough presentation and the Taskforce members for tremendous work. He asked if only state-regulated payors should have to participate, and Dr. Bass agreed that other payors should cover telemedicine services, too. Dr. Bass explained that there was a strong feeling, especially in the Clinical Advisory Group not to limit telemedicine only to rural areas. Dr. Sharfstein said telemedicine would present challenges for the Medicaid budget, and asked what would be the appropriate next steps.

Dr. Merrill said the Taskforce had done a great job, and added that the major advantage of telemedicine for lone rural physicians is contact with specialists. He commented that telemedicine increased accessibility and the technology is being used already to transmit X-rays, though he thought in some areas it may have limited value, such as EKGs.

The Secretary asked if defining infrastructure was a reasonable next step, to which Ben Steffen, Acting Director for the MD Health Care Commission, and Chair of the Telemedicine Taskforce's Financial and Business Model Advisory Group responded that more consensus on technical standards would develop with a maturing Health Information Exchange. Mr. Steffen commented that Maryland will see some reimbursement initiatives launched soon.

Dr. Sharfstein said the Council could accept the report and support technical and clinical discussions on telemedicine. Dr. Bass suggested addressing the state leadership issue and establishing a coordinating and advisory group.

Dr. Jon Shematek made a motion, seconded by Dr. Chesley to accept the Taskforce's report, and to create an advisory group to further address telemedicine services in Maryland. The motion passed on a unanimous voice vote of Council members present.

Health Care Delivery Reform Workgroup – Laura Herrera, DHMH

Dr. Herrera's presentation was deferred to the Council's next meeting as Internet access in the meeting room was unreliable, and Dr. Herrera's focus was to demonstrate the workgroup's website as a tool for developing clinical services and payment innovations. The website currently is in draft form, but can be reviewed at:
http://www.dhmh.maryland.gov/healthreform/SitePages/subcommittee.aspx

Maryland Multipayer PCMH Program - Ben Steffen, Maryland Health Care Commission

Mr. Steffen introduced Ms. Susan Myers as the Maryland Multipayer Patient Centered Medical Home program's manager. Ms. Myers has served with the PCMH program as it has developed, and previously served as a local health officer in Pennsylvania.

Mr. Steffen briefly reported that the program is on schedule, with all but four of the 52 participating practices having submitted their NCQA Recognition applications. There are 339 participating clinicians caring for 235,000 patients in the program. The total of a $1 Million payment for Cycle Two in the program's first year is scheduled for release in early January, 2012. The program's Learning Collaborative has conducted discipline- specific webinars for the various health care professionals in the participating practices, and quarterly practice transformation meetings.

Secretary Sharfstein thanked Mr. Steffen for his report, and asked that the program update the Council whenever significant data become available on the program's progress and impact on its selected indicators.

ACTION ITEMS

GUEST PRESENTATION

High Deductible Health Plans – Cindy Otley, CareFirst

Secretary Sharfstein introduced Ms. Cindy Otley, Product Director at CareFirst BlueCross BlueShield, who discussed "Consumer Driven Health Plans" (CDH), which are High Deductible Health Plans paired with a tax-preferred savings account that is used to pay for qualified healthcare expenses. Ms. Otley's presentation is available on the Council's website.

Ms. Otley explained that while these plans require all medical and prescription benefits to be subject to a high deductible, they do encourage members to seek preventive care by allowing that care to be covered at 100 percent. Tying these high deductible plans to tax preferred savings accounts allows members to save pre tax money to cover the cost of the deductible and other out of pocket costs. The plans integrate the health care benefits with the administration of these savings accounts. Carriers provide online tools to help members make informed decisions about their care. The concept aims to create wiser, more informed consumers who make better healthcare choices because they pay more out of pocket and want to save money.

Ms. Otley showed that there are two different types of savings accounts for the plans: Health Savings Accounts which are portable, tax-advantaged bank accounts, funded by the employee and/or employer, and Health Reimbursement Accounts s which are employer-owned "accounts" used to reimburse employees for eligible medical-related expenses on a non-taxable basis.

Data show that in the CareFirst region, the move to CDH occurred in the most vulnerable, price sensitive segments – Maryland Small Group and Individuals over 65 years of age. In the Small Group Employer CDH adoption rates grew from 17 percent in 2007 to 41 percent in 2010. The Maryland Small Group Reform (MSGR) market has the highest penetration of CDH, representing 58 percent of MSGR enrollment. The Individual over-65 segment penetration is 28 percent. In Small Group, CDH premiums averaged 45-60 percent less than Non-CDH in 2008, and average 29 – 54 percent less today. Ms. Otley said that CDH mainstreamed much faster than expected because it was too good to pass up.

Dr. Sharfstein asked how the CDH works for health, with chronic disease patients having to pay out of pocket for health care needs. He added that two thirds of the plans being sold are CDH, and people are not getting primary care. Ms. Otley explained that mechanisms are in place to mitigate the cost. She said members are saving a lot of money, and employers are saving so much, that they're contributing so members' deductible is almost covered.

Dr. Merrill commented that there is a huge gap in cost to individuals as many businesses are not contributing. Ms. Otley explained that the Maryland Small Group Market is shrinking and that employers are dropping coverage because they can't afford it. She said the thought behind the shift in cost to the consumer was it would cost-sensitize people more, make them more cautious and wise in seeking health care services. This has been difficult to prove. Ms. Otley said care utilization dropped in 2010 and early 2011, but this had more to do with the down turn in the economy then with the impact of high deductibles.

The percent of Maryland Small Group employers offering insurance has fallen from 41 percent in 2007 to 35 percent in 2010. Members in the over-65 Individual market pay on average 57 percent less for a CDH plan vs. a Maryland Small Group member. This is attributed to medical underwriting (more favorable risk), which goes away in 2014. Once a group or individual selects CDH, most either remain in CDH or go uninsured. Of the individuals who had CDH but left CareFirst, 37 percent moved to CDH with another carrier and 38 percent went uninsured. In small group 62.5 percent of employers moved to CDH with another carrier and 17.5 percent dropped coverage. So, Ms Otley said, the last stop before dropping insurance is CDH. And with

CDH making up 58 percent of the MSGR, those groups are potentially one step away from dropping coverage.

Ms. Otley noted that an Aetna five-year study of two million members showed equivalent and sometimes higher compliance with therapies among those with CDH, as members with traditional plans. Dr. Shematek commented that in 2011, CareFirst has seen significant utilization decrease for all products, but especially for CDH. He said that there is a huge misunderstanding among patients and providers about the preventive care benefits. Dr. Shematek offered to share future CareFirst data on CDHs.

Ms. Otley discussed the impact of State Exchanges on health plans. Product offerings must conform to uniform standards – resulting in little differentiation on anything except price. This could lead to a movement among employers from Defined Benefit to Defined Contribution where the employer provides a defined dollar amount to be used toward the cost of the employee premium. It could mean that employees are offered a greater array of product choices including ancillaries to meet their needs, while employers preserve the tax advantage for providing insurance.

Ms. O'Kane added that Pitney-Bowes' diabetic employees had a high fall-off, so they re-designed the benefit package to cover medications from the first dollar. Ms. O'Kane asked what can the State do to protect Maryland residents with impending changes. The Secretary said the Council will continue to gather information on High Deductible Health Plans, and to follow the issue in the coming year.

Council's 2011 Annual Report to the General Assembly

Dr. Chesley made the motion, seconded by Dean Reece to accept the Council's 2011 Annual Report, distributed to the members prior to the meeting. The motion passed on a unanimous voice vote of the Council members present.

NEXT STEPS

Secretary Sharfstein reminded members that the next meeting of the Council is March 12, 2012 from 9:30 AM to12 noon at the UMBC Technology Center. The meeting then adjourned at 12:07 PM.